		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044859

Facility Name: Wauconda Healthcare and Rehab

Address: 176 Thomas Court (Number) Wauconda (City) 60084 (Zip Code)

County: Lake

Telephone Number: (847) 526-5551 **Fax #** (847) 526-0807

HFS ID Number: 36-4343848

Date of Initial License for Current Owners: 1st May 2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2005 to 31-Dec-2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 31st March 2006 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds May 9th 2005

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	125	44,601	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	125	44,601	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,183	1,554	4,952	10,689	8
9	SNF/PED					9
10	ICF	24,464	5,079	6	29,549	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,647	6,633	4,958	40,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.22%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1st May 2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1st May 2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 125 and days of care provided 4,892

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 31st Dec 2005 Fiscal Year: 31st Dec 2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,465	28,665	8,340	311,470		311,470		311,470			1
2	Food Purchase		213,448		213,448	(11,803)	201,645	(341)	201,304			2
3	Housekeeping	211,029	57,444		268,473		268,473		268,473			3
4	Laundry	43,794	32,178		75,972		75,972		75,972			4
5	Heat and Other Utilities			159,105	159,105		159,105		159,105			5
6	Maintenance	14,435	67,219	141,382	223,036		223,036	1,562	224,598			6
7	Other (specify):*											7
8	**TOTAL General Services**	543,723	398,954	308,827	1,251,504	(11,803)	1,239,701	1,221	1,240,922			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	2,228,461	124,920	41,592	2,394,973		2,394,973		2,394,973			10
10a	Therapy											10a
11	Activities	80,047	33,176	824	114,047		114,047		114,047			11
12	Social Services	88,188		1,998	90,186		90,186		90,186			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,396,696	158,096	52,814	2,607,606		2,607,606		2,607,606			16
	C. General Administration											
17	Administrative	78,677		193,700	272,377		272,377	(123,161)	149,216			17
18	Directors Fees											18
19	Professional Services			127,176	127,176		127,176	11,776	138,952			19
20	Dues, Fees, Subscriptions & Promotions			45,504	45,504		45,504	(37,607)	7,897			20
21	Clerical & General Office Expenses	156,201	40,133	66,462	262,796		262,796	11,834	274,630			21
22	Employee Benefits & Payroll Taxes			497,900	497,900	11,803	509,703	35,718	545,421			22
23	Inservice Training & Education			755	755		755	785	1,540			23
24	Travel and Seminar			4,908	4,908		4,908	3,374	8,282			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			8,363	8,363		8,363		8,363			26
27	Other (specify):* *Payroll Taxes (Sch.VII)**							10,851	10,851			27
28	**TOTAL General Administration**	234,878	40,133	944,768	1,219,779	11,803	1,231,582	(86,430)	1,145,152			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,175,297	597,183	1,306,409	5,078,889		5,078,889	(85,209)	4,993,680			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wauconda Healthcare and Rehab #0044859 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,964	34,964		34,964	8,151	43,115			30
31	Amortization of Pre-Op. & Org.							967	967			31
32	Interest			6,981	6,981		6,981	472,357	479,338			32
33	Real Estate Taxes			56,330	56,330		56,330		56,330			33
34	Rent-Facility & Grounds			1,200,000	1,200,000		1,200,000	(770,760)	429,240			34
35	Rent-Equipment & Vehicles			11,127	11,127		11,127		11,127			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,309,402	1,309,402		1,309,402	(289,285)	1,020,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		203,907	360,576	564,483		564,483		564,483			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,902	66,902		66,902		66,902			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		203,907	427,478	631,385		631,385		631,385			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,175,297	801,090	3,043,289	7,019,676		7,019,676	(374,494)	6,645,182			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,785	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(341)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,684)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,850)	21		24
25	Fund Raising, Advertising and Promotional	(55,736)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,200)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(318)	20		28
29	Other-Attach Schedule **Per page 5A attached	1,562	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (95,782)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(278,712)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (278,712)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (374,494)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Wauconda Healthcare and Rehab

ID# 0044859

Report Period Beginning: 1-Jan-2005

Ending: 31-Dec-2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Costs (expended in 2005)	$ (1,532)	6	1
2	Deferred Maintenance Costs (to write off in 2005)	3,094	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,562		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(341)	0	0	0	0	0	0	0	0	0	0	(341)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,562	0	0	0	0	0	0	0	0	0	0	1,562	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,221	0	0	0	0	0	0	0	0	0	0	1,221	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(123,161)	0	0	0	0	0	0	0	0	0	(123,161)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,776	0	0	0	0	0	0	0	0	0	11,776	19
20	Fees, Subscriptions & Promotions	(56,054)	18,447	0	0	0	0	0	0	0	0	0	(37,607)	20
21	Clerical & General Office Expenses	(47,050)	56,684	2,200	0	0	0	0	0	0	0	0	11,834	21
22	Employee Benefits & Payroll Taxes	0	35,718	0	0	0	0	0	0	0	0	0	35,718	22
23	Inservice Training & Education	0	785	0	0	0	0	0	0	0	0	0	785	23
24	Travel and Seminar	(1,684)	5,058	0	0	0	0	0	0	0	0	0	3,374	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	10,851	0	0	0	0	0	0	0	0	0	10,851	27
28	**TOTAL General Administration**	(104,788)	16,158	2,200	0	0	0	0	0	0	0	0	(86,430)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(103,567)	16,158	2,200	0	0	0	0	0	0	0	0	(85,209)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Wauconda Healthcare and Rehab** **#** **0044859** **Report Period Beginning:** **1-Jan-2005** **Ending:** **31-Dec-2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	7,785	366	0	0	0	0	0	0	0	0	0	8,151	30
31	Amortization of Pre-Op. & Org.	0	0	967	0	0	0	0	0	0	0	0	967	31
32	Interest	0	(47,822)	520,179	0	0	0	0	0	0	0	0	472,357	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(770,760)	0	0	0	0	0	0	0	0	(770,760)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,785	(47,456)	(249,614)	0	0	0	0	0	0	0	0	(289,285)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,782)	(31,298)	(247,414)	0	0	0	0	0	0	0	0	(374,494)	45

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 43,704	$ 43,704	1
2	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	10,851	10,851	2
3	V	17	Management Fee Income	193,700	Lancaster, Ltd.	100.00%		(193,700)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	11,776	11,776	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	56,684	56,684	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	35,718	35,718	6
7	V	24	Seminars & Travel		Lancaster, Ltd.	100.00%	5,058	5,058	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	26,835	26,835	8
9	V	20	Marketing and Fees		Lancaster, Ltd.	100.00%	17,571	17,571	9
10	V	32	Interest	47,160	Lancaster, Ltd.	100.00%	(662)	(47,822)	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	366	366	11
12	V	20	Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	876	876	12
13	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	785	785	13
14	Total			$ 240,860			$ 209,562	$ * (31,298)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 1,200,000	Wauconda Associates	100.00%	$ 429,240	$ (770,760)	15
16	V	32	Interest		Wauconda Associates	100.00%	520,179	520,179	16
17	V	31	Amortization		Wauconda Associates	100.00%	967	967	17
18	V	21	Illinois Replacement Tax		Wauconda Associates	100.00%	2,200	2,200	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,200,000			$ 952,586	$ * (247,414)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	33.34%	See Attached	2	4.17%	Lancaster	$ 8,750	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00%	See Attached	5	10.42%	Lancaster	17,477	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0.00%	See Attached	5	10.42%	Lancaster	17,477	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,704		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: -Dec-2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 604.4416
Fax Number: (773) 478.1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 210,000	$ 210,000	2	$ 8,750	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		2	398	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	5	17,477	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		5	931	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	5	17,477	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		5	931	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		193,700	11,776	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	193,700	56,684	14
15	22	Employee Benefits	Management Fees	2,140,820	7	394,769		193,700	35,718	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		193,700	5,058	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	193,700	26,835	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	193,700	17,571	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		193,700	(662)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		193,700	366	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		193,700	876	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		193,700	8,591	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		193,700	785	23
24	32	*Direct Interest*								24
25	TOTALS					$ 2,381,147	$ 1,575,768		$ 209,562	25

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	JP Morgan Chase Bank		X	Working Capital							(662)	6
7	Harston Investments		X	Working Capital							480,000	7
8												8
9	TOTAL Facility Related						$	$			$ 479,338	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 479,338	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Wauconda Healthcare and Rehab **#** 0044859 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 58,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 56,130	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,670)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 59,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 56,330	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	56,580	8
	2001	59,283	9
	2002	56,766	10
	2003	58,529	11
	2004	56,130	12

****Accrual is based on average of last 4 year's taxes adjusted for inflation****

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wauconda Healthcare and Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0044859

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-35-200-009	Long-Term HealthCare	$ 49,672.71	$ 49,672.71
2.	09-35-200-059	Long-Term HealthCare	$ 6,263.85	$ 6,263.85
3.	09-35-200-057	Long-Term HealthCare	$ 193.75	$ 193.75
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 56,130.31	$ 56,130.31

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 14,507
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 967
4. Dates Incurred: 1st May 2000

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Redwood Sign 4x6			2000	2,862	183	20	184	1	1,215	9
10	Nurses' Call System			2001	18,785	1,320	20	1,886	566	14,070	10
11	Fire Protection System			2001	99,420	6,988	20	9,983	2,995	74,465	11
12	Nurse Call Additions			2002	1,100	96	20	74	(22)	244	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 122,167	$ 8,587		$ 12,127	$ 3,540	$ 89,994	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 151,733	$ 17,698	$ 24,361	$ 6,663	5	$ 88,039	71
72	Current Year Purchases	35,746	7,149	4,731	(2,418)	5	4,731	72
73	Fully Depreciated Assets	20,884	1,530	1,530			20,884	73
74	**Lancaster Allocation**		366	366			1,976	74
75	TOTALS	$ 208,363	$ 26,743	$ 30,988	$ 4,245		$ 115,630	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 330,530	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,330	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,115	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,785	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 205,624	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wauconda Associates **an unrelated entity**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 429,240			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 429,240 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1-May-2000
Ending 30-Apr-2007

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 462,029
13.	12/31/2007	$ 465,010
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 11,127 Description: Copier @$908.34 for 7 months & @$953.76 for 5 months
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 173,849	$		$ 173,849	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,526			10,526	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			176,201			176,201	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				169,575		169,575	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**Medical Supplies**	39-2					11,129		11,129	13
	Other (specify): **Specialty Beds**	39-2					23,203		23,203	
14	TOTAL			$		$ 360,576	$ 203,907		$ 564,483	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,463	$ 1,463	1
2	Cash-Patient Deposits	52,206	52,206	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,554,262	1,554,262	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,061	40,061	6
7	Other Prepaid Expenses	575	575	7
8	Accounts Receivable (owners or related parties)	368	368	8
9	Other(specify): **Refundable Deposits**	775	775	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,649,710	$ 1,649,710	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	122,167	122,167	15
16	Equipment, at Historical Cost	207,921	207,921	16
17	Accumulated Depreciation (book methods)	(258,563)	(258,563)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		14,507	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,507)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Option Deposit**		3,600,000	22
23	Other(specify): **Construction-in-Progress**	57,200	2,494,774	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 128,725	$ 6,166,299	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,778,435	$ 7,816,009	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 186,706	$ 186,706	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,206	52,206	28
29	Short-Term Notes Payable	488,980	1,070,843	29
30	Accrued Salaries Payable	303,606	303,606	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,236	14,236	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,000	59,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,104,734	$ 1,686,597	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,104,734	$ 5,686,597	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 673,701	$ 2,129,412	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,778,435	$ 7,816,009	48

***(See instructions.)**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 754,170	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 754,170	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(80,469)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (80,469)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 673,701	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,212,467	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,212,467	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,945	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Shareholders Loan**	750,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 916,945	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,129,412	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,075,400	1
2	Discounts and Allowances for all Levels	(1,376,228)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,699,172	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	870,928	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 870,928	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	339,601	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,176	19
20	Radiology and X-Ray	3,130	20
21	Other Medical Services	20,200	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 369,107	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,939,207	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,251,504	31
32	Health Care	2,607,606	32
33	General Administration	1,219,779	33
	B. Capital Expense		
34	Ownership	1,309,402	34
	C. Ancillary Expense		
35	Special Cost Centers	564,483	35
36	Provider Participation Fee	66,902	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,019,676	40
41	**Income before Income Taxes (line 30 minus line 40)****	(80,469)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (80,469)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. **Cash Basis Taxpaye**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,983	2,055	$ 69,983	$ 34.05	1
2	Assistant Director of Nursing	1,167	1,214	33,309	27.44	2
3	Registered Nurses	31,711	33,978	860,694	25.33	3
4	Licensed Practical Nurses	5,351	6,142	133,968	21.81	4
5	CNAs & Orderlies	82,821	88,808	1,096,547	12.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,971	2,033	27,837	13.69	9
10	Activity Assistants	5,060	5,403	52,210	9.66	10
11	Social Service Workers	5,278	5,863	88,188	15.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,517	27,580	274,465	9.95	15
16	Dishwashers					16
17	Maintenance Workers	1,352	1,401	14,435	10.30	17
18	Housekeepers	24,516	26,202	211,029	8.05	18
19	Laundry	4,879	5,100	43,794	8.59	19
20	Administrator	2,157	2,239	78,677	35.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,887	11,652	156,201	13.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,893	2,200	33,960	15.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,543	221,870	$ 3,175,297 *	$ 14.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	220	$ 8,340	1-3	35
36	Medical Director	234	8,400	9-3	36
37	Medical Records Consultant	114	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	185	5,255	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	824	11-3	44
45	Social Service Consultant	56	1,998	12-13	45
46	Other(specify) **Dimentia**	200	6,512	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,041	$ 35,553		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	764	$ 23,301	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	95	2,300	10-3	52
53	TOTAL (lines 50 - 52)	859	$ 25,601		53

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Farlee (through Apr '05)	Administrator	N/A	$ 32,085
Sue Prostko (effective Apr '05)	Administrator	N/A	46,592
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,677

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 193,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 193,700
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Accu-Med Services Inc.	Data Processing	$ 1,800
E-Health Data Solutions	Data Processing	2,430
Health Data Systems	Data Processing	3,127
Personnel Planners	Unemployment Tax Consult.	1,425
Richard Peelo	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,555
Stone, Pogrund & Korey	Legal	114,589
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 127,176

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,818
Unemployment Compensation Insurance	32,258
FICA Taxes	235,590
Employee Health Insurance	127,793
Employee Meals	11,803
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	12,437
Retirement Plan Contributions	6,626
Employment Fees	29,378
Lancaster Allocation	35,718
TOTAL (agree to Schedule V, line 22, col.8)	$ 545,421

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
** N/A **		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,252
Health Care Worker Background Check	2,300
(Indicate # of checks performed 153)	
Advertising & Promotions	37,607
Licenses and Fees	379
Dues and Subscriptions	976
Lancaster Allocation	18,447
Less: Public Relations Expense	(37,289)
Non-allowable advertising	(18,447)
Yellow page advertising	(318)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,897

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,624
Seminar Expense	3,284
Lancaster Allocation	5,058
Entertainment Expense	(1,684)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,282

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting & Decorating	Mar-2004	$ 1,000	3	$	$	$ 167	$ 333	$ 333	$ 167	$	$	$
2	Painting & Decorating	Apr-2004	2,000	3			333	667	667	333			
3	Painting & Decorating	Apr-2004	5,515	3			920	1,838	1,837	920			
4	Painting & Decorating	Sep-2005	1,532	3				256	510	510	256		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 10,047		$	$	$ 1,420	$ 3,094	$ 3,347	$ 1,930	$ 256	$	$

Facility Name & ID Number Wauconda Healthcare and Rehab # 0044859 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,961** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **66,902**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,803** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.